

		FOR OHF USE					

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**2000**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2000)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0038604</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>BEVERLY FARM FOUNDATION</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/99</u> to <u>06/30/00</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
<b>Address:</b> <u>6301 HUMBERT ROAD</u> <u>GODFREY</u> <u>62035</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
<b>County:</b> <u>MADISON</u>		<b>Officer or Administrator of Provider</b> (Signed) _____ (Date) _____	
<b>Telephone Number:</b> <u>(618) 466-0367</u> Fax # ( ) _____		(Type or Print Name) <u>MARTHA WARFORD</u>	
<b>IDPA ID Number:</b> <u>37-1237369001</u>		(Title) <u>EXECUTIVE DIRECTOR</u>	
<b>Date of Initial License for Current Owners:</b> _____		(Signed) _____ (Date) _____	
<b>Type of Ownership:</b>		<b>Paid Preparer</b> (Print Name and Title) <u>KIMBERLY S. KRUEGER</u>	
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT		(Firm Name & Address) <u>SCHEFFEL &amp; COMPANY, P.C.</u> <u>106 COUNTY RD. JERSEYVILLE, IL 62052</u>	
<input checked="" type="checkbox"/> Charitable Corp.		(Telephone) <u>(618) 498-6841</u> Fax # <u>(618) 498-6842</u>	
<input type="checkbox"/> Trust		<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
IRS Exemption Code _____			
<input type="checkbox"/> PROPRIETARY			
<input type="checkbox"/> Individual			
<input type="checkbox"/> Partnership			
<input type="checkbox"/> Corporation			
<input type="checkbox"/> "Sub-S" Corp.			
<input type="checkbox"/> Limited Liability Co.			
<input type="checkbox"/> Trust			
<input type="checkbox"/> Other _____			
<b>GOVERNMENTAL</b>			
<input type="checkbox"/> State			
<input type="checkbox"/> County			
<input type="checkbox"/> Other _____			
<b>In the event there are further questions about this report, please contact:</b> Name: <u>BRENDA MILLER</u> Telephone Number: <u>(618) 466-0367</u>			

Facility Name & ID Number BEVERLY FARM FOUNDATION# 0038604 Report Period Beginning: 07/01/99 Ending: 06/30/00**III. STATISTICAL DATA**A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	<u>300</u>	Intermediate/DD	<u>300</u>	<u>109,500</u>	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>300</u>	TOTALS	<u>300</u>	<u>109,500</u>	7

**B. Census-For the entire report period.**

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	<u>90,752</u>	<u>7,647</u>		<u>98,399</u>	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>90,752</u>	<u>7,647</u>		<u>98,399</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 89.86%

D. How many bed-hold days during this year were paid by Public Aid?

1,807 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)DAY CARE (RESPITE CARE)F. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒ NO ☐

I. On what date did you start providing long term care at this location?

Date started 10/01/57

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date \_\_\_\_\_ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number  
of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary \_\_\_\_\_

**IV. ACCOUNTING BASIS**ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 06/30/00 Fiscal Year: 06/30/00

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

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Facility Name &amp; ID Number

BEVERLY FARM FOUNDATION

# 0038604

Report Period Beginning:

07/01/99

Ending:

06/30/00

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	596,901	81,072	162,825	840,798		840,798		840,798		1
2	Food Purchase		681,086		681,086		681,086	(9,878)	671,208		2
3	Housekeeping	274,127	21,410	471,718	767,255		767,255		767,255		3
4	Laundry	311,621	42,527		354,148		354,148		354,148		4
5	Heat and Other Utilities			244,869	244,869		244,869		244,869		5
6	Maintenance	289,955	28,399	145,818	464,172		464,172		464,172		6
7	Other (specify):* SECURITY	9,917	1,063	136,058	147,038		147,038		147,038		7
8	<b>TOTAL General Services</b>	1,482,521	855,557	1,161,288	3,499,366		3,499,366	(9,878)	3,489,488		8
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	3,424,170	140,980	1,543,873	5,109,023	(259,698)	4,849,325		4,849,325		10
10a	Therapy	214,630	4,051	45,299	263,980		263,980		263,980		10a
11	Activities	204,823	44,818	35,278	284,919		284,919		284,919		11
12	Social Services	112,599		1,763	114,362		114,362		114,362		12
13	Nurse Aide Training	92,232			92,232	259,698	351,930		351,930		13
14	Program Transportation	39,325			39,325		39,325		39,325		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	4,087,779	189,849	1,626,213	5,903,841		5,903,841		5,903,841		16
	<b>C. General Administration</b>										
17	Administrative	122,334		57,094	179,428		179,428		179,428		17
18	Directors Fees										18
19	Professional Services			175,467	175,467		175,467		175,467		19
20	Dues, Fees, Subscriptions & Promotions			70,346	70,346		70,346		70,346		20
21	Clerical & General Office Expenses	350,405	33,632	184,526	568,563		568,563		568,563		21
22	Employee Benefits & Payroll Taxes			1,800,143	1,800,143		1,800,143		1,800,143		22
23	Inservice Training & Education			2	2	6,102	6,104		6,104		23
24	Travel and Seminar			15,554	15,554	(6,102)	9,452		9,452		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			71,671	71,671		71,671		71,671		26
27	Other (specify):* FUNDRAISING	64,512		18,589	83,101		83,101	(83,101)			27
28	<b>TOTAL General Administration</b>	537,251	33,632	2,393,392	2,964,275		2,964,275	(83,101)	2,881,174		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	6,107,551	1,079,038	5,180,893	12,367,482		12,367,482	(92,979)	12,274,503		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

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Facility Name & ID Number **BEVERLY FARM FOUNDATION**

#0038604

Report Period Beginning:

07/01/99

Ending:

06/30/00

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			1,007,997	1,007,997		1,007,997	(343,123)	664,874			30
31	Amortization of Pre-Op. & Org.			11,264	11,264		11,264		11,264			31
32	Interest			488,073	488,073		488,073	(209,971)	278,102			32
33	Real Estate Taxes			10,463	10,463		10,463	(10,463)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* <b>MORTGAGE INS.</b>			32,508	32,508		32,508		32,508			36
37	<b>TOTAL Ownership</b>			1,550,305	1,550,305		1,550,305	(563,557)	986,748			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	41,014	6,557	77,753	125,324		125,324		125,324			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			620,936	620,936		620,936		620,936			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>	41,014	6,557	698,689	746,260		746,260		746,260			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	6,148,565	1,085,595	7,429,887	14,664,047		14,664,047	(656,536)	14,007,511			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(9,878)	2-7		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(343,123)	30-7		9
10	Interest and Other Investment Income	(209,971)	32-7		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(10,463)	33-7		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(83,101)	27-7		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (656,536)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
37	<b>(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (656,536)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

NON-ALLOWABLE EXPENSES		Sch. V Line
	Amount	Reference
1	\$	1
2		2
3		3
4		4
5		5
6		6
7		7
8		8
9		9
10		10
11		11
12		12
13		13
14		14
15		15
16		16
17		17
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74		74
75		75
76		76
77		77
78		78
79		79
80		80
81		81
82		82
83		83
84		84
85		85
86		86
87		87
88		88
89		89
90 Total	0	90

## Summary A

# 0038604

**Report Period Beginning:**

**07/01/99**

**Ending:**

**06/30/00**

**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

[illegible]

## Summary B

**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

[illegible]



**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		GROUP HOME #1	GODFREY			
		GROUP HOME #2	GODFREY			
		GROUP HOME #3	GODFREY			
		GROUP HOME #4	GODFREY			
		GROUP HOME #5	GODFREY			
		GROUP HOME #6	GODFREY			

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.** ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		GROUP HOME #1	GODFREY			
		GROUP HOME #2	GODFREY			
		GROUP HOME #3	GODFREY			
		GROUP HOME #4	GODFREY			
		GROUP HOME #5	GODFREY			
		GROUP HOME #6	GODFREY			

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.** ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **BEVERLY FARM FOUNDATION** # **0038604** Report Period Beginning: **07/01/99** Ending: **06/30/00**

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number **BEVERLY FARM FOUNDATION**# **0038604**

Report Period Beginning:

**07/01/99**Ending: **06/30/00**

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization **GROUP HOMES 1 - 6**

Street Address

City / State / Zip Code

Phone Number

Fax Number

**GODFREY, IL 62035****( 618) 466-0367****( )**

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22-3	EMPLOYEE BENEFITS	WAGES	1	8	\$ 2,899,056	\$ 0	62.0941%	\$ 1,800,143	1
2	17-3	SCHOOL REIMBURSEMENTS	WAGES	1	8	2,741	0	62.0941%	1,702	2
3	20-3	PUBLIC RECORDS CHECKS	WAGES	1	8	10,287	0	62.0941%	6,388	3
4	17-1	ADMINISTRATIVE SALARIES	DAYS/HOURS	2,080	8	203,890	203,889	1,248	122,334	4
5	21-1	PERSONNEL/ACCOUNTING	DAYS/HOURS	2,080	8	459,407	459,407	1,248	275,644	5
6	6-1	MAINTENANCE STAFF	DAYS/HOURS	2,080	8	483,259	483,259	1,248	289,955	6
7	7-3	SECURITY	DAYS/HOURS	2,080	8	226,764	0	1,248	136,058	7
8	7-1	GUARDS	DAYS/HOURS	2,080	8	16,529	16,529	1,248	9,917	8
9	7-2	SECURITY SUPPLIES	DAYS/HOURS	2,080	8	1,771	0	1,248	1,063	9
10	6-2	MAINTENANCE SUPPLIES	DAYS/HOURS	2,080	8	38,676	0	1,248	23,206	10
11	21-2	SOFTWARE UPGRADES	DAYS/HOURS	2,080	8	11,415	0	1,248	6,849	11
12	21-3	OSHA REQUIREMENTS	DAYS/HOURS	2,080	8	26,057	0	1,248	15,634	12
13	26-3	INSURANCE	DAYS/HOURS	2,080	8	119,452	0	1,248	71,671	13
14	19-3	LEGAL & ACCOUNTING	DAYS/HOURS	2,080	8	292,445	0	1,248	175,467	14
15	14-1	TRANS. COORDINATOR	DAYS/HOURS	2,080	8	65,541	65,541	1,248	39,325	15
16	20-3	DUES, SUBS, ADVERTISING	DAYS/HOURS	2,080	8	106,288	0	1,248	63,773	16
17	36-3	MORTGAGE INS.	DAYS/HOURS	2,080	8	54,180	0	1,248	32,508	17
18	32-3	INTEREST	DAYS/HOURS	2,080	8	769,815	0	1,248	461,889	18
19	31-3	BOND AMORTIZATION	DAYS/HOURS	2,080	8	18,773	0	1,248	11,264	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 5,806,346	\$ 1,228,625		\$ 3,544,790	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	IL HEALTH FACILITY		X	CONSTRUCTION		7/96	\$	\$ 6,814,299	2031	6.6800	\$ 461,889	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	MISCELLANEOUS										24,684	6	
7												7	
8												8	
9	TOTAL Facility Related						\$	\$ 6,814,299			\$ 486,573	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$	\$ 6,814,299			\$ 486,573	15	

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Facility Name & ID Number **BEVERLY FARM FOUNDATION**# **0038604** Report Period Beginning: **07/01/99** Ending: **06/30/00****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$ <b>10,463</b>	2
3. Under or (over) accrual (line 2 minus line 1).	\$ <b>10,463</b>	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$ <b>10,463</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	<b>4,951</b>	8		
	1996	<b>5,352</b>	9		
	1997	<b>5,071</b>	10	13	FROM R. E. TAX STATEMENT FOR 1999 \$ 13
	1998	<b>5,317</b>	11	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	1999	<b>5,822</b>	12	15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

A. Square Feet:
 \_\_\_\_\_

B. General Construction Type:
 Exterior
 BRICK
 Frame
 WOOD & STEEL
 Number of Stories
 ONE

C. Does the Operating Entity?
 ☒ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).
 \_\_\_\_\_
 \_\_\_\_\_
 \_\_\_\_\_
 \_\_\_\_\_
 \_\_\_\_\_
 \_\_\_\_\_

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO
 If so, please complete the following:

1. Total Amount Incurred:
 \_\_\_\_\_

2. Number of Years Over Which it is Being Amortized:
 \_\_\_\_\_

3. Current Period Amortization:
 \_\_\_\_\_

4. Dates Incurred:
 \_\_\_\_\_

Nature of Costs:
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)
 \_\_\_\_\_

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	FACILITY	6,701,800	1955	\$ 78,120	1
2	GROUND IMP.		VARIOUS	113,772	2
3	TOTALS	6,701,800		\$ 191,892	3

Facility Name & ID Number **BEVERLY FARM FOUNDATION**# **0038604**

Report Period Beginning:

07/01/99

Ending:

06/30/00

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	129		1960	1960	\$ 340,034	\$ 8,501	40	\$ 8,501		\$ 333,804	4
5	26		1965	1965	166,210	4,155	40	4,155		145,433	5
6	35		1969	1969	309,300	7,732	40	7,732		239,706	6
7	26		1972	1972	277,051	6,926	40	6,926		193,935	7
8	41		1979	1979	628,784	15,720	40	15,720		345,832	8
	<b>Improvement Type**</b>										
9	BUILDING ADDITIONS			1968	416,642	10,998	40	10,998		314,036	9
10	BUILDING IMPROVEMENTS			1973	1,958	48	40	48		1,321	10
11	BUILDING ADDITIONS			1974	62,866	1,571	40	1,571		40,870	11
12	BUILDING IMPROVEMENTS			1977	6,665	166	40	166		3,839	12
13	BUILDING IMPROVEMENTS			1978	29,299	731	40	731		16,102	13
14	BUILDING IMPROVEMENTS			1979	3,697	92	40	92		1,932	14
15	BUILDING IMPROVEMENTS			1980	178,379	4,458	40	4,458		89,178	15
16	BUILDING IMPROVEMENTS			1981	31,403		10			31,403	16
17	BUILDING IMPROVEMENTS			1982	12,792		10			12,792	17
18	BUILDING IMPROVEMENTS			1981	95,850	2,391	40	2,391		44,316	18
19	BUILDING IMPROVEMENTS			1982	11,260	282	40	282		5,217	19
20	CERAMIC FLOOR			1982	1,282	32	40	32		545	20
21	SIDEWALK			1983	23,174		10			23,174	21
22	SEWER			1983	72,357	2,412	30	2,412		41,003	22
23	SERVICE ROAD			1983	35,016		15			35,016	23
24	BUILDING IMPROVEMENTS			1984	24,029	599	40	599		9,910	24
25	BUILDING IMPROVEMENTS			1983	21,405	535	40	535		8,829	25
26	WADING POOL & FENCE			1984	16,290	543	15	543		16,290	26
27	SIDEWALK			1984	15,477		10			15,477	27
28	ENTRANCE SIGNS			1985	1,770		12			1,770	28
29	DRAINAGE SWAIL			1984	18,096	562	15	562		18,096	29
30	ROAD REPAIRS			1985	1,670	96	15	96		1,670	30
31	ELECTRICAL SYSTEM			1985	20,407	1,022	20	1,022		15,817	31
32	BUILDING IMPROVEMENTS			1985	10,135	255	40	255		3,929	32
33	BUILDING IMPROVEMENTS			1985	7,675	191	40	191		2,973	33
34	BUILDING IMPROVEMENTS			1986	1,107	27	40	27		404	34
35	BUILDING IMPROVEMENTS			1986	46,643	1,163	40	1,163		16,901	35
36	<b>TOTAL (lines 4 thru 35)</b>				\$ 2,888,723	\$ 71,208		\$ 71,208		\$ 2,031,520	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.



## STATE OF ILLINOIS

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Facility Name & ID Number **BEVERLY FARM FOUNDATION**# **0038604**

Report Period Beginning:

**07/01/99**

Ending:

**06/30/00****XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	43		1984	1984	\$ 1,188,870	\$ 29,722	40	\$ 29,722		\$ 460,688	4
5											5
6											6
7											7
8											8
		Improvement Type**									
9		BUILDING IMPROVEMENTS		1986	26,832	669	40	669		9,725	9
10		BUILDING IMPROVEMENTS		1986	36,519	910	40	910		13,232	10
11		BUILDING IMPROVEMENTS		1986	31,221	779	40	779		11,320	11
12		BUILDING IMPROVEMENTS		1986	2,363	59	40	59		865	12
13		BUILDING IMPROVEMENTS		1986	4,353	108	40	108		1,569	13
14		AIR CONDITION SYSTEM		1986	591,935	39,464	15	39,464		572,205	14
15		PLAYGROUND SHELTER		1985	16,220	1,083	15	1,083		15,681	15
16		SIDEWALKS		1985	9,742		10			9,742	16
17		ROAD PAVING & LOT		1985	41,930	2,796	15	2,796		40,532	17
18		SEWER & STORM DRAIN		1985	5,422	179	30	179		2,619	18
19		GROUND IMPROVEMENTS		1985	3,117		10			3,117	19
20		SIDEWALKS		1986	15,081		10			15,081	20
21		PARKING LOT		1986	1,838	121	15	121		1,653	21
22		BENCHES & FENCES		1986	5,058	338	15	338		4,553	22
23		AIR CONDITION SYSTEM		1986	5,000	335	15	335		4,502	23
24		BUILDING REMODELING		1986	46,415	1,163	40	1,163		15,668	24
25		BUILDING REMODELING		1986	41,122	1,029	40	1,029		13,880	25
26		BUILDING IMPROVEMENTS		1986	216,453	5,411	40	5,411		73,052	26
27		BOILER		1987	14,533	364	40	364		4,542	27
28		ELECTRIC REWIRE		1987	16,869	845	20	845		10,545	28
29		BUILDING IMPROVEMENTS		1986	2,341	58	40	58		1,216	29
30		BUILDING IMPROVEMENTS		1987	78,723	1,969	40	1,969		24,224	30
31		BUILDING IMPROVEMENTS		1987	8,447	212	40	212		2,534	31
32		SEWER & MANHOLE		1987	830	58	15	58		695	32
33		TREE REMOVAL		1987	2,091	141	15	141		1,744	33
34		TELEPHONE SYSTEM		1988	4,086	205	20	205		2,350	34
35		BUILDING IMPROVEMENTS		1988	1,810	46	40	46		521	35
36		TOTAL (lines 4 thru 35)			\$ 2,419,221	\$ 88,064		\$ 88,064		\$ 1,318,055	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **BEVERLY FARM FOUNDATION**# **0038604**

Report Period Beginning:

07/01/99

Ending:

06/30/00

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		PARKING LOT		1988	42,125	2,810	15	2,810		32,298	9
10		SEWER		1988	22,785	757	30	757		8,732	10
11		FENCE		1988	1,147	79	15	79		882	11
12		BUILDING IMPROVEMENTS		1990	3,527	176	10	176		3,527	12
13		SEWER		1990	3,459	346	10	346		3,286	13
14		BUILDING IMPROVEMENTS		1991	27,118	677	40	677		6,439	14
15		SPRINKLER		1991	50,681	5,068	10	5,068		48,147	15
16		DINING HALL		1991	940,888	23,523	40	23,523		211,701	16
17		SEWER REPAIR		1989	1,904	95	10	95		1,904	17
18		PARKING LOT RESURFACING		1989	9,918	662	15	662		6,943	18
19		CLEAN DUMP		1989	4,821	242	10	242		4,821	19
20		MANHOLE REPLACEMENT		1991	4,100	411	10	411		3,896	20
21		SEWER REPAIRS		1991	1,062	106	10	106		1,009	21
22		SEWER REPAIRS		1991	6,513	652	10	652		6,188	22
23		DINING HALL		1991	4,625	113	40	113		1,038	23
24		RENOVATIONS-CAMPBELL		1992	4,282	173	25	173		1,543	24
25		SIDEWALKS		1992	10,289	1,028	10	1,028		9,259	25
26		ROOM ADDITION-CAMPBELL		1992	38,900	1,556	25	1,556		11,672	26
27		WINDOWS-LOGAN		1992	16,450	658	25	658		4,935	27
28		DOORS/WINDOWS/REMODELLING-ALL 10 COTTAGES		1993	1,422,666	56,330	25	56,330		426,210	28
29		SEWER LINE/ROADWORK/PAVILION		1993	21,585	1,856	10 \ 15	1,856		13,925	29
30		NEW ROOF/CONCRETE WORK		1994	43,633	2,909	15	2,909		18,908	30
31		REMODELED BEVERLY, SMITH & STAHL BLDGS		1993	567,401	22,695	25	22,695		147,523	31
32		FURNACE/AIR CONDITIONER/SPRINKLER		1994	13,403	535	25	535		3,484	32
33		ROAD & LOT WORK		1994	21,688	1,446	15	1,446		9,398	33
34		FLOW METER		1994	5,755	383	15	383		2,493	34
35		SIDEWALK & DRAINAGE WORK		1995	10,534	1,054	10	1,054		6,847	35
36		<b>TOTAL (lines 4 thru 35)</b>			\$ 3,301,259	\$ 126,340		\$ 126,340	\$	\$ 997,008	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **BEVERLY FARM FOUNDATION**# **0038604**

Report Period Beginning:

**07/01/99**

Ending:

**06/30/00****XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		CABINETS		1995	5,460	364	15	364		2,002	9
10		BAZEBO		1995	8,490	566	15	566		3,113	10
11		WINDOWS		1995	41,000	1,640	25	1,640		9,020	11
12		PARKING LOT REPAIRS/SPRINKLER/FIRE ALARM		1994	1,272	51	25	51		280	12
13		ROAD WORK		1994	76,071	5,072	15	5,072		27,893	13
14		SEWER & GAS LINES		1995	12,104	1,212	10	1,212		6,659	14
15		AIRCOND/FLOORING/CEILING REPAIR/PAVILION		1996	26,015	1,041	25	1,041		4,683	15
16		KITCHEN AT LOGAN		1996	7,494	500	15	500		2,249	16
17		PARKING LOT & ROAD		1996	164,403	16,440	10	16,440		73,981	17
18		PATIO & SIDEWALK		1996	13,517	1,352	10	1,352		6,083	18
19		GAS & WATER LINES EVANS HALL		1996	1,347	134	10	134		605	19
20		WINDOWS		1998	11,490	766	15	766		2,681	20
21		PORCH - CHAPPE		1998	4,110	206	20	206		720	21
22		LIGHTING/ROOF DRAINS/DIETARY REPAIRS		1998	11,782	786	15	786		2,750	22
23		PARKING LOT		1997	78,536	7,854	10	7,854		27,488	23
24		SIDEWALK		1997	11,311	452	25	452		1,583	24
25		SEWER REPAIR		1997	4,232	423	10	423		1,481	25
26		LANDSCAPING		1997	9,668	1,934	5	1,934		6,768	26
27		SIDEWALKS		1997	4,125	413	10	413		1,444	27
28		PARKING LOT		1997	3,876	388	10	388		1,357	28
29		ADMINISTRATION BUILDING		1997	667,309	16,683	40	16,683		58,390	29
30		SECURITY OFFICE		1997	3,399	340	10	340		850	30
31		CARPET/LINOLEUM/LAVATORY/SUNROOM		1997	21,007	1,401	15	1,401		3,502	31
32		ROOFS-HERRING & DONNELLY		1997	55,560	3,704	15	3,704		9,260	32
33		CABINETS - DONNELLY		1998	10,638	709	15	709		1,773	33
34		ROOF- LAUNDRY		1998	20,652	1,377	15	1,377		3,442	34
35		ROOF REPAIR DONNELLY/NEW DOORS/FURNACE		1997	16,030	1,069	15	1,069		2,672	35
36		<b>TOTAL (lines 4 thru 35)</b>			\$ 1,290,898	\$ 66,877		\$ 66,877	\$	\$ 262,729	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **BEVERLY FARM FOUNDATION**# **0038604**

Report Period Beginning:

**07/01/99**

Ending:

**06/30/00****XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
		<b>Improvement Type**</b>									
9		HARDWARE - ADMINISTRATION BLDG		1997	6,556	656	15	656		1,311	9
10		SECURITY SYSTEM - ADMINISTRATION BLDG		1997	2,046	205	10	205		409	10
11		PARKING LOT/SIDEWALKS/SEWER REPAIR/FENCE		1998	65,738	6,574	10	6,574		15,577	11
12		WINDOWS/ROOF REPAIRS/DOORS		1999	96,828	3,873	25	3,873		5,810	12
13		WINDOWS - LAUNDRY		1999	6,670	267	25	267		400	13
14		DOORS - MAINTENANCE		1999	13,314	1,331	10	1,331		1,997	14
15		WINDOWS-NURSING		1998	6,182	247	25	247		370	15
16		FENCE - LAGOON		1999	6,734	449	15	449		673	16
17		ROAD REPAIR		1999	6,667	667	10	667		1,000	17
18		WATER LINE REPAIR ADMIN		1999	564	56	10	56		84	18
19		SIDEWALKS		1999	22,706	2,271	10	2,271		3,406	19
20		PATIO - DONNELLY		1999	1,020	102	10	102		153	20
21		WINDOWS - CAMPBELL		1993	440	18	25	18		133	21
22		PARKING LOT REPAIRS/SPRINKLER/FIRE ALARM		1994	9,528	381	25	381		2,096	22
23		ROOF-CAMP BEVERLY		2000	1,350	34	20	34		34	23
24		BEVERLY COTTAGE-SIDING,GUTTERS, FASCIA		2000	8,636	216	20	216		216	24
25		CARRIAGE HOUSE-WINDOWS		2000	586	12	25	12		12	25
26		CHAPPE-ROOF		1999	615	15	20	15		15	26
27		DIETARY-DOOR		1999	3,262	163	10	163		163	27
28		DONNELLY-DOORS		2000	6,927	346	10	346		346	28
29		EVANS-SIDING & GUTTERS		1999	10,527	263	20	263		263	29
30		FUNDRAISING-SIDING & GUTTERS		1999	2,125	53	20	53		53	30
31		GARAGE-WINDOW		1999	909	18	25	18		18	31
32		MAIN CAMPUS GAS LINE		1999	10,235	256	20	256		256	32
33		HERRING-SIDING & GUTTERS		1999	5,788	145	20	145		145	33
34		HERRING-DOOR		2000	2,857	143	10	143		143	34
35		HILLIER-ROOF		2000	34,732	868	20	868		868	35
36		<b>TOTAL (lines 4 thru 35)</b>			\$ 333,542	\$ 19,629		\$ 19,629	\$	\$ 35,951	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		HILLIER-SPRINKLER & FLOORING		1999	12,663	317	20	317		317	9
10		HOUSEKEEPING-SOFFIT & GUTTERS		1999	925	23	20	23		23	10
11		LAUNDRY-DOOR,SIDING & SOFFIT		1999	2,586	65	20	65		65	11
12		LAVENTHAL-DOOR,SIDING & SOFFIT		1999	5,972	149	20	149		149	12
13		LOGAN-DOOR,SOFFIT,FLOORING		1999	18,805	470	20	470		470	13
14		OLD HERRING-SIDING		1999	1,172	29	20	29		29	14
15		SMITH-DOOR,SIDING & FASCIA		1999	9,851	246	20	246		246	15
16		STAHL-SIDING,SOFFIT & FLOORING		2000	14,075	352	20	352		352	16
17		SUPPLY-SIDING & SOFFIT		1999	3,806	95	20	95		95	17
18		GAS PIPELINE		1999	4,000	200	10	200		200	18
19		TAR/CHIP ROADS		1999	12,403	620	10	620		620	19
20		GASOLINE TANK		1999	2,788	139	10	139		139	20
21		ASPHALT WORK		1999	74,611	3,731	10	3,731		3,731	21
22		WATERLINES		1999	23,855	1,193	10	1,193		1,193	22
23		CHAPPEE-SIDEWALK		1999	1,515	76	10	76		76	23
24		FENCE ABOVE LPG VAPOR TANK		2000	4,200	140	15	140		140	24
25		HERRING-PARKING LOT		1999	3,493	175	10	175		175	25
26		HILLIER-SIDEWALK		1999	3,466	173	10	173		173	26
27		LOGAN-PATIO		1999	10,258	513	10	513		513	27
28		GROUND COVER FOR SWING SET		1999	5,962	298	10	298		298	28
29		OLD HERRING-ELECTRIC		2000	2,579	129	10	129		129	29
30		SMITH SIDEWALK		1999	1,063	53	10	53		53	30
31		TREE REMOVAL		2000	875	88	5	88		88	31
32											32
33											33
34											34
35											35
36		<b>TOTAL (lines 4 thru 35)</b>			\$ 220,923	\$ 9,274		\$ 9,274	\$	\$ 9,274	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 1,928,888	\$ 218,847	\$ 218,847	\$	5-20	\$ 1,087,717	37
38	Current Year Purchases	428,623	25,947	25,947		5-20	25,947	38
39	Fully Depreciated Assets	1,230,852				5-20	1,230,852	39
40								40
41	TOTALS	\$ 3,588,363	\$ 244,794	\$ 244,794	\$		\$ 2,344,516	41

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	MAINTENANCE	CAPITALIZED REPAIRS	1998	\$ 3,428	\$ 686	\$ 686	\$		\$ 1,714	42
43	WHEEL CHAIR VAN	79 VAN	1997	2,500	500	500			1,250	43
44	MAINTENANCE	85 FORD TRUCK	1984	12,796					12,796	44
45	RESIDENT TRANS.	94 DODGE VANS (2)	1994	21,000					21,000	45
46	TOTALS			\$ 39,724	\$ 1,186	\$ 1,186	\$		\$ 36,760	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 14,551,302	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 664,874	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 664,874	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 7,202,113	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	DAY TRAINING BUILDING	\$ 1,763,261	\$ 46,807	\$ 446,533	52
53	TOMBSTONES	3,186	212	2,230	53
54	DAY TRAINING EQUIPMENT	553,569	54,517	419,666	54
55	GROVES B. SMITH BUILDING	1,083,245	28,539	165,152	55
56	GROVES B. SMITH EQUIPMENT	106,601	10,210	53,366	56
57	TOTALS	\$ 3,509,862	\$ 140,285	\$ 1,086,947	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$	\$	\$	\$		\$	37
38	Current Year Purchases							38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	\$	\$	\$	\$		\$	41

**D. Vehicle Depreciation (See instructions.)\***

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	WHEEL CHAIR LIFT	CAPITALIZED EXPENSE	1996	\$ 9,480	\$ 1,896	\$ 1,896	\$		\$ 8,532	42
43	LIFT GRATE VAN	CAPITALIZED EXPENSE	1996	1,960	391	391			1,763	43
44	MAINTENANCE	97 FORD TRUCK	1997	14,139	2,828	2,828			9,897	44
45	MAINTENANCE	FORD TRUCK	1997	8,500	1,700	1,700			4,250	45
46	TOTALS			\$ 34,079	\$ 6,815	\$ 6,815	\$		\$ 24,442	46

**E. Summary of Care-Related Assets**

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$	51

**F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)**

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	ADMINISTRATION BUILDING	\$ 112,652	\$ 2,924	\$ 10,018	52
53	ADMINISTRATION EQUIPMENT	9,294	1,655	5,102	53
54	GIFT SHOP EQUIPMENT	4,100	820	2,196	54
55	TREIN VOCATIONAL BUILDING	737,598	19,750	19,750	55
56	TREIN EQUIPMENT	4,143	324	324	56
57	TOTALS	\$ 867,787	\$ 25,473	\$ 37,390	57

**G. Construction-in-Progress**

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XI. OWNERSHIP COSTS (continued)**

**C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$	\$	\$	\$		\$	37
38	Current Year Purchases							38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	\$	\$	\$	\$		\$	41

**D. Vehicle Depreciation (See instructions.)\***

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	RESIDENT TRANS.	CAPITALIZED REPAIRS	1995	\$ 1,051	\$ 106	\$ 106	\$		\$ 1,051	42
43	RESIDENT TRANS.	96 CHEVROLET VAN	1996	15,570	3,114	3,114			14,013	43
44	WHEET CHAIR VAN	96 WHEEL CHAIR VAN	1996	20,699	4,141	4,141			18,632	44
45	RESIDENT TRANS.	96 LUMINA VAN	1996	15,827	3,165	3,165			14,243	45
46	TOTALS			\$ 53,147	\$ 10,526	\$ 10,526	\$		\$ 47,939	46

**E. Summary of Care-Related Assets**

	1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 49
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 51

**F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)**

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	DAYCARE BUILDING	\$ 30,420	\$ 1,985	\$ 4,002	52
53	HARDIN APARTMENTS	768,021	22,132	199,354	53
54	GREENHOUSE	332,541	11,842	104,706	54
55	ARENA EQUIPMENT	68,181	7,312	57,364	55
56	HARDIN APTS. EQUIPMENT	185,275	8,380	109,226	56
57	TOTALS	\$ 1,384,438	\$ 51,651	\$ 474,652	57

**G. Construction-in-Progress**

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.



**C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$	\$	\$	\$		\$	37
38	Current Year Purchases							38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	\$	\$	\$	\$		\$	41

**D. Vehicle Depreciation (See instructions.)\***

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	WHEEL CHAIR VAN	95 CHEVROLET VAN	1995	\$ 36,398	\$ 3,637	\$ 3,637	\$		\$ 36,398	42
43	TRANSPORT SUPPLIES	95 CHEVROLET VAN	1995	17,167	1,718	1,718			17,167	43
44	RESIDENT TRANS.	95 CHEVROLET CORSICA	1995	12,567	1,258	1,258			12,567	44
45	MAINTENANCE	94 J.D. 4 WD TRACTOR	1995	11,485	1,148	1,148			11,485	45
46	TOTALS			\$ 77,617	\$ 7,761	\$ 7,761	\$		\$ 77,617	46

**E. Summary of Care-Related Assets**

	1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 49
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 51

**F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)**

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	HORTICULTURE BUILDING	\$ 120,067	\$ 4,214	\$ 35,014	52
53	GROUP HOMES	2,409,267	65,595	479,265	53
54	GROUP HOMES EQUIPMENT	390,237	44,541	282,677	54
55	GROUP HOMES VEHICLES	61,222	7,582	52,651	55
56	GROUP HOMES LAND	30,000			56
57	TOTALS	\$ 3,010,793	\$ 121,932	\$ 849,607	57

**G. Construction-in-Progress**

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XI. OWNERSHIP COSTS (continued)**

**C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$	\$	\$	\$		\$	37
38	Current Year Purchases							38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	\$	\$	\$	\$		\$	41

**D. Vehicle Depreciation (See instructions.)\***

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	RESIDENT TRANS.	99 FORD VAN	1999	\$ 15,025	\$ 3,005	\$ 3,005	\$		\$ 4,507	42
43	MAINTENANCE	99 FORD PICKUP	1999	24,000	4,800	4,800			7,200	43
44	MAINTENANCE	87 CHEV. BUCKET TRUCK	2000	9,000	900	900			900	44
45	RESIDENT TRANS.	95 FORD VAN	2000	10,013	1,001	1,001			1,001	45
46	TOTALS			\$ 58,038	\$ 9,706	\$ 9,706	\$		\$ 13,608	46

**E. Summary of Care-Related Assets**

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$	51

**F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)**

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	OTHER LAND	\$ 60,462	\$	\$	52
53	ARENA	124,506	3,782	22,381	53
54					54
55					55
56					56
57	TOTALS	\$ 184,968	\$ 3,782	\$ 22,381	57

**G. Construction-in-Progress**

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$	\$	\$	\$		\$	37
38	Current Year Purchases							38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	\$	\$	\$	\$		\$	41

**D. Vehicle Depreciation (See instructions.)\***

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	RESIDENT TRANS.	99 FORD VAN	1999	\$ 53,876	\$ 2,694	\$ 2,694	\$		\$ 2,694	42
43										43
44										44
45										45
46	TOTALS			\$ 53,876	\$ 2,694	\$ 2,694	\$		\$ 2,694	46

**E. Summary of Care-Related Assets**

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$	51

**F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)**

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

**G. Construction-in-Progress**

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

## XII. RENTAL COSTS

### A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease \_\_\_\_\_.

9. Option to Buy: ☐ YES ☐ NO Terms: \_\_\_\_\_ \*

### B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

### C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_/2001 \$ \_\_\_\_\_

13. \_\_\_\_\_/2002 \$ \_\_\_\_\_

14. \_\_\_\_\_/2003 \$ \_\_\_\_\_

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

**A. TYPE OF TRAINING PROGRAM** (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b>  <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<b>2. CLASSROOM PORTION:</b>  IN-HOUSE PROGRAM <input checked="" type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  COMMUNITY COLLEGE <input type="checkbox"/>  HOURS PER AIDE <u>40</u>	<b>3. CLINICAL PORTION:</b>  IN-HOUSE PROGRAM <input checked="" type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  HOURS PER AIDE <u>80</u>
---	--	---

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies	1,850	10,100		11,950
3	Classroom Wages (a)	8,979	118,203		127,182
4	Clinical Wages (b)		198,768		198,768
5	In-House Trainer Wages (c)	991	13,039		14,030
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$ 11,820	\$ 340,110	\$	\$ 351,930
10	SUM OF line 9, col. 1 and 2 (e)	\$ 351,930			

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$

**D. NUMBER OF AIDES TRAINED**

<b>COMPLETED</b>	
1. From this facility	404
2. From other facilities (f)	
<b>DROP-OUTS</b>	
1. From this facility	74
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>478</b>

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist	10a-3	hrs	\$		973
2	Licensed Speech and Language Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care	39-3	visits		39	47,506		39	47,506		5
6	Dental Care	39-1/39-3/39-2	visits	41,014	123	38,850	6,557	123	86,421		6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescripts								9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								
10	Academic Education		hrs								10
11	Exceptional Care Program										11
12											12
13	Other (specify):										13
14	TOTAL			\$ 41,014	1,135	\$ 131,655	\$ 6,557	1,135	\$ 179,226		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 4,830,603	\$	1
2	Cash-Patient Deposits	97,634		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 33,916 )	2,558,793		3
4	Supply Inventory (priced at COST )	94,555		4
5	Short-Term Investments	1,321,600		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	98,560		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): PLEDGES RECEIVABLE	58,884		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 9,060,629	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	337,716		12
13	Land	1,018,582		13
14	Buildings, at Historical Cost	18,047,465		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	5,293,103		16
17	Accumulated Depreciation (book methods)	(9,673,090)		17
18	Deferred Charges	706,911		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	334		22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 15,731,021	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 24,791,650	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 603,287	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	97,634		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	368,437		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<b>OTHER ACCRUED LIABILITIES</b>	475,539		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,544,897	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	11,396,734		41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 11,396,734	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 12,941,631	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 11,850,019	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 24,791,650	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$ 13,567,531</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$ 13,567,531</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(2,613,511)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>SEE ATTACHED</b>	<b>895,999</b>	<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ (1,717,512)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 11,850,019</b>	<b>24 *</b>

\* This must agree with page 17, line 47.



**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 10,738,335	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 10,738,335	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	850,010	24
25	Interest and Other Investment Income***	273,684	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,123,694	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	SEE ATTACHED	188,507	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 188,507	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 12,050,536	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	3,499,366	31
32	Health Care	5,903,841	32
33	General Administration	2,964,275	33
<b>B. Capital Expense</b>			
34	Ownership	1,550,305	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	125,324	35
36	Provider Participation Fee	620,936	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 14,664,047	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(2,613,511)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (2,613,511)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

## STATE OF ILLINOIS

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Facility Name & ID Number **BEVERLY FARM FOUNDATION**# **0038604**Report Period Beginning: **07/01/99**

Ending:

**06/30/00****XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,159	2,359	\$ 47,974	\$ 20.34	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,132	3,228	43,888	13.60	3
4	Licensed Practical Nurses	37,835	42,439	504,171	11.88	4
5	Nurse Aides & Orderlies	272,400	292,704	2,534,437	8.66	5
6	Nurse Aide Trainees	7,024	7,652	92,232	12.05	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	16,423	18,003	204,823	11.38	10
11	Social Service Workers	7,405	8,115	112,599	13.88	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	79,757	88,169	596,901	6.77	15
16	Dishwashers					16
17	Maintenance Workers	27,280	30,445	289,955	9.52	17
18	Housekeepers	32,480	34,744	274,127	7.89	18
19	Laundry	28,878	31,808	311,621	9.80	19
20	Administrator	1,951	2,053	66,890	32.58	20
21	Assistant Administrator					21
22	Other Administrative	3,108	3,453	55,444	16.06	22
23	Office Manager					23
24	Clerical	28,113	31,618	350,405	11.08	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	20,470	21,815	273,804	12.55	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,869	2,117	19,896	9.40	31
32	Other Health Care(specify)					32
33	Other(specify)	22,119	24,529	369,398	15.06	33
34	TOTAL (lines 1 - 33)	592,403	645,251	\$ 6,148,565 *	\$ 9.53	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

**B. CONSULTANT SERVICES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	12 mths	\$ 43,670	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	12 mths	5,616	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	PSYCHOLOGIST CONSULTANT	46	13,800		47
48					48
49	TOTAL (lines 35 - 48)	46	\$ 63,086		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name &amp; ID Number BEVERLY FARM FOUNDATION

## **XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
MONTE WELKER	EXECUTIVE DIRECTOR	0	\$ 36,005	Workers' Compensation Insurance		\$ 231,801	IDPH License Fee	\$	
MARTHA WARFORD	EXECUTIVE DIRECTOR	0	30,885	Unemployment Compensation Insurance		44,151	Advertising: Employee Recruitment	20,345	
BRENDA MILLER	BUSINESS OFFICE MGR	0	30,322	FICA Taxes		465,754	Health Care Worker Background Check	6,388	
STEVE PATSAROS	PERSONNEL MANAGER	0	25,122	Employee Health Insurance		888,254	(Indicate # of checks performed <u>532</u> )		
				Employee Meals			DUES & SUBSCRIPTIONS	19,343	
				Illinois Municipal Retirement Fund (IMRF)*			LICENSE	627	
				PENSION		74,520	BOND FEES	3,465	
				PHYSICALS/DRUG TESTS		20,100	ADMINISTRATOR FEES	20,178	
				MISCELLANEOUS BENEFITS		75,563			
TOTAL (agree to Schedule V, line 17, col. 1)							Less: Public Relations Expense	(	
(List each licensed administrator separately.)			\$ 122,334				Non-allowable advertising	(	
B. Administrative - Other							Yellow page advertising	(	
TOTAL (agree to Schedule V, line 17, col. 1)							TOTAL (agree to Sch. V,		
(Attach a copy of any management service agreement)			\$ 1,702				line 20, col. 8)		
C. Professional Services				TOTAL (agree to Schedule V,			\$ 70,346		
Vendor/Payee	Type		Amount	line 22, col.8)					
SEE ATTACHED AND			\$	E. Schedule of Non-Cash Compensation Paid			G. Schedule of Travel and Seminar**		
ALLOCATION WORKSHEET	LEGAL FEES		141,735	to Owners or Employees					
SCHEFFEL & COMPANY	ACCOUNTING & AUDITING		33,732	Description	Line #	Amount	Description	Amount	
						\$	Out-of-State Travel	\$	

\* Attach copy of IMRF notifications

**\*\*See instructions.**

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

[illegible]

Facility Name & ID Number BEVERLY FARM FOUNDATION

STATE OF ILLINOIS

# 0038604

Report Period Beginning:

07/01/99

Ending:

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06/30/00

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. IARF 10787
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 5 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line \_\_\_\_\_
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 620,936  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ \_\_\_\_\_ Has any meal income been offset against related costs? YES Indicate the amount. \$ 9,878
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 0%  
d. Have vehicle usage logs been maintained? YES  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES  
g. Does the facility transport residents to and from day training? NO  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? YES  
Firm Name: SCHEFFEL & COMPANY, P.C. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees.

REAL ESTATE TAXES ON PAGE 10 OF THE COST REPORT ARE ON LAND HELD  
FOR INVESTMENT PURPOSES.

DAY TRAINING	\$3,661,157
APARTMENTS & INCIDENTALS	406,244
GROUP HOMES	3,431,404
GIFT SHOP	61,331
TREASURES & TRINKETS	5,299
	<u>\$7,565,435</u>

EXPENSES INCURRED BY BROAD CATEGORY  
NOT LISTED IN THIS COST REPORT

DAY TRAINING	\$3,234,389
APARTMENTS	300,233
GROUP HOMES	3,054,221
GIFT SHOP	61,331
GREENHOUSE	13,963
TREASURES & TRINKETS	5,299
	<u>\$6,669,436</u>
NET INCOME	<u>\$ 895,999</u>

SERVICE	1	2	3	4
	HRS. WORKED	HRS. PAID	WAGES	HOURLY WAGE
PHYSICAL THERAPY	10,557	11,964	\$ 166,434	13.91
SPEECH THERAPY	1,967	2,111	48,196	22.83
GUARDS	1,224	1,272	9,917	7.80
DENTAL ASST.	3,440	3,810	41,014	10.76
TRANSPORTATION COORDINATOR	1,096	1,202	39,325	32.72
DEVELOPMENT DIRECTOR	1,976	2,168	38,932	17.96
FUNDRAISING SECRETARY	1,859	2,002	25,580	12.78
	22,119	24,529	\$ 369,398	



SODA MACHINE	\$ 9,878
HAB-AIDE REIMBURSEMENT	71,950
IPA TRANSPORTATION REIMBURSEMENT	3,011
FARM INCOME	860
INSURANCE - STORM DAMAGE	48,842
WORK. COMP PREMIUM REFUND	34,084
RENT INCOME	1,399
ALLEN FOODS - VOLUME INCENTIVE	5,805
MISCELLANEOUS	12,678
	<u>\$188,507</u>